BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF THE INTAKE OF THE HABIT CLINIC FOR CHILD GUIDANCE, INC.

A Thesis

Submitted by

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CHAPTER I

METHOD AND PURPOSE

In the past quarter century or more, knowledge of the emotional life of the child as well as the art of helping him has grown tremendously. "Concurrently, public interest in these matters and understanding of them have grown."[1] It is with this in mind that this study is being undertaken, primarily to determine the changing role of the Habit Clinic for Child Guidance, Inc. in Boston, over the past twenty-five years as is reflected by its intake. Special emphasis will be placed upon the changes in the geographic areas the Clinic services; changes in the problems referred; changes in the family backgrounds of the children as well as changes in the sources of referral.

To have made an analysis of all the cases known to Clinic since its inception in 1921 would have been a physical impossibility for the writer to do in the period of time allotted for this study. Therefore, a sample of three hundred cases was chosen, each one-hundred cases representing one of three periods in the Clinic's history; namely, the first three years, the middle three years and the last three years. The writer will refer to these periods as Period I, II, and III, respectively: Period I representing the years 1922, 1923, 1924; Period II, the years 1933, 1934, 1935; and Period III, the years 1943, 1944, 1945. Because the Clinic was not started

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1 Helen Leland Witmer, Psychiatric Clinics for Children, p. 9.

CHAPTER I

METHOD AND PURPOSE

until November of 1921, the writer has chosen the year 1922 as the first full year of the Clinic's existence.

These three-year periods were chosen arbitrarily because they cover the periods of time in which the investigator is interested. The fact that each period happens to be of social and economic significance as well is purely coincidental. It will be noted, however, that Period I does happen to represent the era of prosperity following World War I, Period II the Depression era, and Period III the World War II era.

The three groups of one hundred cases each were picked at random to include every third case in Period I, every fifth case in Period II, and every sixth case in Period III, as recorded in the Intake Book of the agency. The reason for this method of picking the cases is accounted for when one considers that the total intake amounted to 360 patients in Period I, 568 patients in Period II, and 688 patients in Period III. Data for this study was collected from the Intake Book, from case records and from the annual reports of the agency.

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CHAPTER II

THE DEVELOPMENT OF CHILD GUIDANCE CLINICS

As a result of the great mental hygiene movement of the present century, child guidance work emerged as a highly specialized, highly technical profession, the aim of which is to help those children in distress because of unsatisfied inner and outer needs and thus to effect a maximal adjustment in meeting the social and scholastic expectation of their environment. To achieve this end, the child guidance clinics of today aim to study directly and treat each child individually through the combined efforts of a psychiatrist, a psychologist, and a psychiatric social worker. Enabled in this way to obtain a picture of the whole child in relation to his environment, the clinic team is best qualified to treat the causes of the unacceptable behavior of the child, rather than to treat the symptoms superficially.

In general, the function of the child guidance clinics is to study and treat the individual patients and to educate the community at large regarding the prevention of behavior and personality disorders in children. Some clinics also provide for research on case material in an effort to contribute to the field of child psychology as well as to help provide opportunity for the training of students of psychiatry and social work.

"Historically, however, child guidance work owes its existence to the broader concern of various groups with the age-old and overwhelming

CHAPTER II

THE DEVELOPMENT OF CHILD GUIDANCE CLINICS

problems of delinquency, mental disease and dependency."[1] As methods for dealing with these problems were laid down, it became possible to experiment with the various psychiatric, psychological and social work techniques towards a closer type of individual study. For, as knowledge and understanding of behavior in general increased, it became more and more evident that many tendencies towards delinquency, mental illness and dependency were discernable in childhood and that these problems were partially due to early environmental influences upon the individual. Thus it was natural for clinic workers to deduce that prevention of these tendencies and their consequences should begin early.

Adolph Myer, in his work with psychotics, early in this century emphasized the need of preventive work with children. He was convinced, through his study of individual patients, that the basis for many neuroses and psychoses was laid down in early childhood. Sigmund Freud's contributions towards the understanding and treatment of human behavior have certainly reinforced this concept.

Although the term "child guidance" did not appear until 1922, the actual essentials of the clinic scheme appeared prior to this time. Inasmuch as this study does not attempt to deal with the state clinics at all, suffice it to mention here that the earliest clinics for children were connected with state hospitals and schools for the feeble-minded. As far back as 1871,

> The California State Board of Health proposed the erection of a state psychopathic hospital for the treatment of incipient mental disorders because it was believed that much permanent

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1 George E. Stevenson and Geddes Smith, Child Guidance Clinics, A Quarter Century of Development, p. 9.

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insanity was due to the lack of early care.[2] In 1885, the Pennsylvania State Hospital introduced a clinic for children and in 1897 a similar clinic was established at the Boston Dispensary under Dr. Walter Channing. In 1913, psychiatrists at the Boston Psychopathic Hospital were giving special attention to young patients that came to them in the out-patient clinic. But generally speaking, state hospitals rarely accepted children as patients before about 1920.

The first clinic specifically for children, and undoubtedly the pioneer in this field, was the Chicago Juvenile Psychopathic Institute established by Dr. William Healy under the sponsorship of Mrs. W. F. Dummer. This clinic was established in connection with the Chicago Juvenile Court for the study of juvenile offenders, a fact which set this clinic apart from previous organizations whose primary service had been to educate. The work of the Chicago Institute soon began to exert influence throughout the country and in 1917 a similar agency was founded in Boston, namely the Judge Baker Guidance Center. Dr. Healy and his assistant, Dr. Augusta Bronner, were both asked to direct it. Dr. Adler, who had been associated with the Boston Psychopathic Hospital, took over the direction of the Chicago Institute, which was renamed, in 1920, the Institute for Juvenile Research. Established originally under the sponsorship of Cook County, this agency was early taken over by the State of Illinois.

During this same period, the so-called clinic team of social worker, psychologist and psychiatrist came into being. Back in 1912 and 1913 social workers were accepted on the staffs of the Boston Psychopathic Hospital and

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2 Witmer, op. cit., p. 42.

the Henry Phipps Psychiatric Clinic of the Johns Hopkins Hospital. Dr.Adler, when he took over the direction of the Chicago Institute, introduced a social worker on its staff. Similar action was taken by the Judge Baker Guidance Center. Both Judge Baker and the Chicago Institute saw only patients referred by the juvenile court in their early years of existence, whereas the Boston Psychopathic and the Phipps clinics serviced their respective communities at large.

Certainly, the formal establishment of the National Committee for Mental Hygiene in 1909 served to increase the study, care and treatment of the mentally ill and the mentally defective as well as that of the delinquent and the neurotic. At the close of the First World War, both the Smith College School for Social Work and the New York School of Social Work introduced formal training programs in psychiatric social case work. In addition, in 1921, the National Committee for Mental Hygiene, through the Division for the Prevention of Delinquency, established demonstration clinics throughout the country. These clinics were financed by the Commonwealth Fund and their purpose was to demonstrate a method for checking juvenile delinquency.

In this Chapter, the writer has attempted to give a bird's-eye view of the early pioneer clinics for children, all of which helped towards laying the groundwork for the future child guidance clinics in this country.

CHAPTER III

THE HABIT CLINIC FOR CHILD GUIDANCE, INC.

History.

The Habit Clinic for Child Guidance was started in December, 1921, at the instigation of the late Miss Esther Barrow, a social worker associated with the South End House, a settlement. She, together with Dr. Richard M. Smith, a pediatrician, and Drs. Macfie Campbell and Douglas Thom, psychiatrists, organized the plan. "The Clinic was the gradual outgrowth of a long-felt need on the part of doctors, nurses, and parents for the type of scientific help in personality problems that they could obtain in physical care."[1] This clinic differed from already existing clinics in that, "its scope was to be essentially the pre-school age; its method was to be habit training; and its aim was to be of service to the largest possible number at the lowest possible cost."[2] For its founders, convinced of the importance that childhood experiences play in the formation of adult behavior patterns, were particularly anxious to study the origins of a few of the more common forms of adult maladjustments.

Dr. Thom, who until this day has maintained an active interest in the Clinic, has often referred to the period between 1921 and 1927 as a "pioneering period", for during these years the Clinic had no building of

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2 Habit Clinic History, Revised, p. 4.

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its own, no regular staff and very few funds at its disposal. In the first year of its existence it was housed at the South End House, where a children's health clinic was already established. During that year, Dr. Thom volunteered one half-day a week to this project. Gradually, as the demand for its services increased, a second clinic was opened at Roxbury Crossing and a third at Uphams Corner--all three under the auspices of the Baby Hygiene Association.

In 1927, the South End Clinic and the Roxbury Crossing Clinic were united to become "The Habit Clinic". The Uphams Corner Clinic was transferred to the New England Hospital for Women and Children in 1925, and later (1927) was taken over by the State Division of Mental Hygiene. The new Habit Clinic was moved to its own quarters at 48 Rutland Street, Roxbury. The Clinic staff by this time had grown to include two psychiatrists, giving a total of three and a half days a week; two psychologists, giving the same amount of time; a speech worker, giving a half-day a week; and a full-time social worker and secretary. It was now possible to establish teaching contacts for students of social work, psychiatry and psychology, as well as to undertake modest research. In 1933, the Clinic was incorporated and in 1937 it moved to its present building at 15 Autumn Street, Brookline. Student training has continued, the research program has been expanded, and the staff has been increased to meet the demands of the community. Throughout, emphasis has been upon the improvement of the quantity and quality of services to the community.

Dr. Thom has been the Director of the Clinic since its inception. At present he is serving with the armed forces and Dr. Lucie Jessner is the Acting Director in his absence.

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Changes in Clinic Function.

The original purpose of the Habit Clinic had been to give guidance and advice to parents and those working with children on habit training for the pre-school child. Over recent years, it has been noted that there has been a change in the type of problems referred to the Clinic from the more simple kind, dealing with undesirable habits, to a more serious type of personality disorder, falling into the neurotic and delinquent categories. Too, a growing demand for services to older children caused the agency to increase the age limit from pre-school age to ten years, in the early thirties, and then to twelve years in 1942. Both of these factors have brought about a change in the treatment procedure, so that today the social service staff is playing a more dynamic treatment role with the parents. In the past there was considerable stress on the home environment, so that social workers made a great many more home visits, school visits and visits to other agencies. Also, prior to January, 1944, it was customary for the psychiatrist to treat both mother and child, and the social worker was there to get a picture of the environmental situation and carry out the psychiatrist's recommendations. In recent years, the increase in the severity of the problems referred as well as the growing emphasis on the role the parent-child relationship bears upon the problems presented have called for a more intensive type of treatment. Thus, since January, 1944, treatment has been divided between the psychiatrist and the social worker. Inasmuch as the child is the focal point of the agency, the psychiatrist treats the child and the social worker the parent, usually the mother, in an effort to modify some of her attitudes towards the child and his problems. This procedure is not rigidly adhered to, and, as is always the practice, each case is considered

on an individual basis. As Dr. Jessner states:[3]

> It should be kept in mind, however, that the division of treatment between psychiatrist and social worker is much more natural in the case of an older child than when dealing with a child of pre-school age, where the relationship of mother and child is very close, and the child is not yet making an effort to establish independence. Thus we do not want to set up one arbitrary method of handling all cases, but to work out a variety of approaches which will fit the special problems that come to our attention. Specifically, sometimes the psychiatrist will see both mother and child. In other cases she will work with the mother while the social worker sees the child, and vice versa.

There has also been a change in the intake procedure since January, 1944. Formerly, all cases referred, whether or not there had been a clinic contact, were recorded chronologically in the Intake Book. Now, the social workers record in a Day Book all referrals, but only accepted cases, those which have had at least one agency contact, are recorded in the Intake Book.

Clinic Procedure.

When a patient is referred to the clinic, either directly by the mother or by another source, the social worker usually sees the mother first. At this time the problem is clearly defined and the agency function is explained to the mother. Generally, in this application interview, a social history is obtained. Actually, a treatment relationship with the mother is started at this time. If it is a suitable case for the Clinic, the social worker discusses it with the Acting Director and the case is assigned to a psychiatrist, after which a series of weekly appointments is opened up with the psychiatrist seeing the child and the social worker the mother. Interviews for mother and child are scheduled simultaneously.

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Since the mother's interviews almost always last longer than the child's, this year the Clinic has a much-needed playroom worker to supervise the children while they wait. If a child has not had a psychological test, this is usually scheduled early in treatment. Due to the long waiting lists of the psychiatrists, it has been at times necessary to differentiate between emergency and non-emergency cases, the former being given preference when indicated.

Staff conferences are held weekly, attended by psychiatrists, social workers, psychologists, and students in training, as well as by staff members of other agencies active on the cases. Too, as mentioned previously, research is an integral part of the clinic program. Mrs. Helen Edsall carries on the major part of the agency research, assisted by staff members and volunteers. In keeping with the Clinic's original interest in the origins of personality disorders and the preventive aspects of child guidance, case material offers rich resources for this research.

It has always been part of the Clinic's program to educate the public, for it is felt that its work has far wider implications than the actual number of children it serves. "It was one of Dr. Thom's early ideals to extend the benefits of the clinic beyond the immediate patients to an ever-growing circle outside."[4] In keeping with this policy, the clinic staff has made use of clinic material in lecturing and in teaching. Last year a series of radio talks entitled, "Let's Talk about Children," was prepared for the Greater Boston Community Fund campaign.

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4 Habit Clinic History, Revised, p. 12.

CHAPTER IV

A DESCRIPTION OF THE GROUP STUDIED

Geographic Distribution.

It has been most expedient to classify the areas served by the Clinic into the following three geographic groupings: Boston and Suburbs; Metropolitan Area, to include neighboring towns and cities; and Outside Metropolitan Area. This classification follows the grouping used by the Greater Boston 1946 United War Fund. There is included here a map issued by that Organization to illustrate more specifically how the areas are divided.

Table I indicates a marked increase in the geographic radius served by the Clinic today as compared with its earlier years. It is of interest to note that in Period I all one hundred applicants studied fall within the Boston Area; whereas in Period II there are only sixty-three applicants from this area; and in Period III only fifty--exactly one-half of the number in Period I.

Inasmuch as the early clinics were held in the South End, bordering Roxbury, and in Uphams Corner, Dorchester, it is not at all surprising to find that ninety-seven per cent of the applicants in Period I were drawn from these areas: Roxbury leading with forty-six applicants, followed by Boston Proper and Dorchester with twenty-seven and twenty-four respectively. During Periods II and III, on the other hand, there is noted a steady decrease of applicants from these same areas with a corresponding increase of applicants from the Metropolitan Area. In the case of the latter, there is

a rise from zero in Period I to thirty in Period II to forty-one in Period III. Although the greatest number in any one town in the Metropolitan Area come from Brookline and Newton--and this is presumably due to the Clinic's present location--the reader will note that just as great a number of applicants comes from areas at a greater distance.

TABLE I

GEOGRAPHIC DISTRIBUTION OF APPLICANTS

Area	Period I	Period II	Period III
1. Boston and Suburbs	100	63	50
a.Boston Proper	27	19	9
b.Brighton	--	2	7
c.Dorchester	24	19	9
d.Hyde Park	--	2	4
e.Jamaica Plain	--	2	3
f.Roxbury	46	12	11
g.South Boston	2	4	2
h.Other	1	3	5
2. Metropolitan Area	0	30	41
a.Brookline	--	6	9
b.Newton	--	--	10
c.Other	--	24	22
3. Outside Metropolitan Area	--	7	9
Total	100	100	100

From Table I, one notes, too, an increase over the years in the number of applicants from cities and towns outside the Metropolitan Area. In Period III, almost ten per cent of the applicants fall within this category. It is worthy of mention that some of the localities represented were Squantum, Stoughton, Quincy, Lynn, Marblehead, Gloucester, Haverhill and Kingston.

TABLE I

GEOGRAPHIC DISTRIBUTION OF APPLICANTS

Area	Period I	Period II	Period III
1. Boston and Suburbs	100	63	30
a.Boston Proper	27	19	9
b.Brighton	--	2	1
c.Dorchester	24	19	9
d.Hyde Park	--	2	4
e.Jamaica Plain	--	2	3
f.Roxbury	40	12	11
g.South Boston	2	4	2
h.Other	1	3	3
2. Metropolitan Area	0	30	41
a.Brookline	--	6	9
b.Newton	--	--	10
c.Other	--	24	22
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Total	100	100	100

Sources of Referral.

> Mental Hygiene requires something more than a body of theory and a group of practitioners. It requires, in addition, an informed and sympathetic public, that will provide the supporting values and institutions and, in part, will participate in the work.[1]

The sources of referral of an agency may be one indication of the extent of public recognition and understanding of the work of that agency. It is for this reason that the writer is interested in finding out what changes in the sources of referral have occurred in the periods studied. Table II reveals a radical change. In Period I, eighty-four applicants were referred by agencies. Of these, almost fifty per cent were referred by the South Bay Union and the Baby Hygiene Clinics. These two agencies were closely allied with the formation of the Clinic so that it is not at all surprising to find that they constitute such a large percentage of the early referrals. There was a startling drop of agency referrals to thirty-one in Period II and fifteen in Period III. In line with this, however, it is of significance to note that although the total number of agency referrals dropped in these two periods, the number of agencies represented was greater. It is the writer's conviction that these figures do not indicate a lesser need on the part of agencies for clinic services, but rather show a change in the agencies' use of clinic services. It is generally accepted today that, with the more intensive psychiatric training programs set up for social workers, the more simple problems of children are treated directly by the health and social agencies and do not need to be referred for psychiatric service.

Referrals by parents increased from four in Period I to forty-nine in Period II and forty-nine in Period III. Unfortunately, the writer does

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TABLE II

SOURCES OF REFERRAL

Source	Period I	Period II	Period III	Total
Agencies	85	30	15	130
School - Public	--	5	6	11
Parents	4	49	49	102
Other individuals in the community	--	1	3	4
Private physicians	3	--	6	9
Hospitals	5	12	20	37
Others	3	1	1	5
Unknown	--	2	--	2
Total	100	100	100	300

not have available for comparison agency totals for Periods I and II. The percentage of referrals by parents in Period III, however, correlates with the agency's statistics for 1943. There was also a decided increase in hospital referrals from five in Period I to twelve in Period II and twenty in Period III. These figures would indicate that the community at large has been educated to an awareness of the need for preventive work with children in the field of mental hygiene. To go a step further, they show too a rising trend on the part of the members of the community to avail themselves of the psychiatric services at their disposal. The rise in hospital referrals may be viewed as evidence of the greater recognition on the part of the medical profession of the services offered by the Clinic. It will be

TABLE II

SOURCES OF REFERRAL

Source	Period I	Period II	Period III	Total
Agencies	85	90	75	250
School - Public	--	5	6	11
Parents	9	99	93	201
Other individuals in the community	--	1	3	4
Private physicians	3	--	6	9
Hospitals	3	12	20	37
Others	3	1	1	5
Unknown	--	2	--	2
	---	---	---	---
Total	100	100	100	300

noted too that the tendency is towards greater cooperation between the Clinic and the Children's Hospital, which accepts for medical treatment children up to twelve years of age.[3]

Age and Sex Distribution.

Table III shows the age and sex distribution of the applicants in the three periods studied. In Period I, the distribution of the sexes was almost even--fifty-three of the applicants were boys and forty-seven were girls. In Period II, however, sixty-five were boys and thirty-five were girls; the ratio of boys to girls being about two to one. Period III shows an even greater number of boys than the other two periods, with seventy-two boys and only twenty-eight girls, or in other words a little over two-and-a-half times as many boys as girls. In all three periods the number of boys was greater than the number of girls. This ratio of two boys to one girl does not follow the general distribution of boys and girls in the population of Boston. According to the census for the city of Boston in 1920, 1930 and 1940, the sex distribution of children under the age of fourteen was about equally divided, the number of boys being slightly greater than the number of girls.[4]

Table III indicates also a shift in the age group of the applicants. The number of children under six years of age has dropped considerably. Whereas in Period I, eighty-one of the applicants were in this age group, Period III reveals that less than half this number, thirty-four, fall into this group. The trend in the six to twelve age group is in inverse propor-

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3 Table XXII, Appendix.

4 United States Census, 1940, p. 670.

tion, with eighteen applicants in Period I, twenty-eight in Period II, and sixty-four in Period III. One may conclude from these figures that the demand for service to older children is greater in the present day than in the early years of the Clinic. It is not the policy of the Clinic to accept children over twelve years of age, but, again, this is not rigidly adhered to and each case is considered on an individual basis. If a child had been known to Clinic previously, under certain circumstances he will be reaccepted for treatment even if he exceeds the twelve-year-old level. As can be seen from the figures, such cases are rare and their number is insignificant.

TABLE III

AGE AND SEX DISTRIBUTION OF THE APPLICANTS

Age	Period I			Period II			Period III		
In Years	Boys	Girls	Totals	Boys	Girls	Totals	Boys	Girls	Totals
Totals	53	47	100	65	35	100	72	28	100
0-1.9	2	--	2	8	--	8	--	2	2
2-3.9	27	27	54	15	8	23	4	1	5
4-5.9	13	12	25	26	13	39	21	6	27
6-7.9	7	6	13	14	10	24	24	10	34
8-9.9	2	2	4	1	2	3	21	4	25
10-11.9	1	--	1	1	--	1	2	3	5
12-13.9	1	--	1	--	--	0	--	2	2
14-15.9	--	--	0	--	1	1	--	--	0
Unknown	--	--	0	--	1	1	--	--	0

Religious Distribution.

The reader can see from Table IV that the number of Catholic applicants has steadily dropped over the years so that there were half as many in Period III as in Period I. At the same time, the number of Jewish and Protestant applicants shows a steady increase so that their number in Period I more than doubled itself by Period III. The distribution of these three religious sects is more evenly scattered in Period III than in Period I, with the number of Jewish applicants in the lead in Period III. The writer tried to learn the population of the different religious sects in the community, but was unable to do so. It would seem that the reason for such a great number of Catholic children in Period I may be explained by the early location of the Clinic--in the South End and at Uphams Corner. In both these areas, the majority of the residents are Catholic. Brookline, Brighton, Dorchester, and Roxbury have a fairly concentrated Jewish population, and it will be remembered that a large portion of the applicants in Period III came from these areas.

TABLE IV

RELIGION OF APPLICANTS

Religion	Period I	Period II	Period III	Total
African Orthodox	--	1	--	1
Armenian Orthodox	--	1	--	1
Catholic	45	27	21	93
Greek Orthodox	1	2	--	3
Jewish	13	23	32	68
Lettish	1	--	--	1
Mormon	--	2	--	2
Mixed	6	13	7	26
No religious affiliation	--	2	2	4
Protestant	13	16	28	57
Unknown	21	13	10	44
Total	100	100	100	300

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Unknown	21	13	10	44
Total	100	100	100	300

The Problems Presented.

The classification of the problems of the children studied has been a source of difficulty to the writer, since a child's problems may be of multiple causation, arising out of inner and outer tensions, or a combination of both. For a child's development is dynamic, not static, and environmental stimuli, both physical and emotional, act and react upon the process of growth at all times. Thus, unfavorable habits, aggressive and delinquent behavior, etc. are often only symptoms of more basic personality disturbance due to a poor parent-child relationship, to insecurity, or to any number of other reasons. Harold H. Anderson wrote:

> The child's behavior is in reality as much a product of those about him as it is of the child himself. When parents understand this, they can then begin to understand new meaning in child behavior. They can also find new meaning in their own behavior.[5]

It is for this very reason that it is so difficult to classify a specific problem as that of behavior, personality, habit formation, and so forth. For, one or more problems may be due to a single cause, and several causes may underly a single problem. There is, therefore, bound to be some overlapping, as one cannot classify these rigidly.

For the practical purpose of this study, the problems are recorded from the point of view of the symptoms noted by the source of referral at the time of application as well as those recognized and recorded by the worker. They fall into the following main groupings:

1. Problems of habit formation, such as enuresis, soiling, feeding difficulties, masturbation, and thumb-sucking.

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2. Problems of personality reaction, such as nervousness, fearfulness, unmanageableness, aggressiveness, and withdrawn, peculiar behavior.
3. Problems of behavior, such as temper tantrums, sadistic behavior, lying, stealing, and destructiveness.
4. Problems of school, such as poor performance, inability to get along in a group, inattentiveness.
5. Problems of motor disturbance such as speech difficulties, tics, and convulsions.
6. Miscellaneous problems not included in these groupings.

Problems of Habit Formation.

Table V shows the distribution of problems of habit formation in the three periods, and the reader will note the consistent decrease in this type of problem. Figured in percentages, there is a decrease of twenty-two per cent in Period II as compared with Period I, and a decrease of twenty-three and a half per cent in Period III as compared with Period II. The frequency distribution in the various sub-groups is also significant. There is a consistent decrease in feeding problems, in problems of bed-wetting, finger sucking, and masturbation over the years. It would seem that both parents and referring agencies are now better equipped to handle these less serious problems of habit formation without the specialized help of a clinic, thus making it possible for the Clinic to devote more time to intensive work with children presenting more serious problems. It is generally accepted now, that some habits, such as thumb sucking and masturbation, represent certain stages of a child's development and under proper guidance and direction need

2. Problems of personality reaction, such as nervousness, fearfulness, unmanageableness, aggressiveness, and withdrawn, peculiar behavior.

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not necessarily become a problem. When a child presents feeding difficulties or reverts to infantile methods of elimination, it is a fairly certain indication that a basic need is not being met by the parents. Usually, a social worker, a teacher, or any other professional who works with children is able to give the necessary reassurance and guidance to the parent in handling the immediate difficulty.

TABLE V

PROBLEMS OF HABIT FORMATION

Problem	Period I	Period II	Period III
Enuresis	26	16	13
Feeding	27	20	9
Finger sucking	7	10	3
Masturbation	16	5	5
Nail biting	3	4	3
Sleeping	10	3	9
Soiling	3	4	5
Other*	1	6	5
Totals	83	68	52

* Among these are spitting, head banging, nose picking, and biting things.

In a follow-up study made at the Habit Clinic on the first 150 cases the authors write the following regarding problems of habit formation:

In studying this material presented, we find as might be expected

> with the pre-school age group, that the problems we are called on most frequently to treat are those relating to the establishment of the fundamental physical habits of eating, sleeping and eliminating and also those which develop during the general training and discipline of the little child.[6]

Later in this same study the authors conclude:

> We may then conclude from the facts brought out by this study, that in the early cases seen, our therapy has been adequate with greater number of habit problems. We do, however, need to develop more carefully our technique in dealing with the asocial and personality trends. The key to the situation in each instance seems to be in cooperation, which in turn largely means understanding. Therefore, more time must be given by the staff to detailed instruction and effort to make treatment more clear and concrete. Especially more time of the social worker should be available for intensive case work ... We may at the clinic offer advice and suggestions based on our detailed study of the child, but it is our part also to make the parents understand the value of such advice before we can expect a satisfactory response to treatment.[7]

Problems of Personality Reaction.

It is most difficult to determine what makes for a personality problem as criteria are not clearly defined. Therefore, some degree of subjectivity is inevitable. In classifying these problems, the writer has tried to adhere as much as possible to those problems that are most often caused by inner tensions of the individual. To divorce completely the inner tensions from the outer tensions is well nigh impossible because the interplay of both these factors constitutes personality development.

Table VI shows no definite trend in the frequency and distribution of problems of personality reaction. Period II stands out as having just

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6 Dorothy Stebbins and Sybil Foster, "Problems Presented and Results of Treatment on 150 Cases Seen at the Habit Clinic for Preschool Children in Boston," pp. 9-10.

7 Ibid., p. 14.

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TABLE VI

PROBLEMS OF PERSONALITY REACTION

Problem	Period I	Period II	Period III
Aggressiveness	4	1	4
Crying and whining	5	2	3
Fears	13	5	11
Hyperactivity	6	4	8
Irritability & temper	7	0	4
Jealousy	5	2	2
Negativism & defiance	2	3	3
Nervousness & excitability	8	7	11
Stubbornness	12	5	9
Selfishness	2	1	0
Shyness	5	7	4
Sulkiness	1	1	0
Unmanageableness	15	5	25
Withdrawn and peculiar behavior	6	3	6
Other	1	1	5
Totals	92	47	95

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Withdrawn and peculiar behavior	8	3	6
Other	1	1	8
Totals	92	47	95

about half the number of personality problems as the other two periods. The reason for this is not known. Perhaps the economic depression of the thirties is partly responsible for this. During this era parents were too much taken up with the more immediate worries of livelihood and survival to bother with these more serious, but more subtle personality deviations.

Problems of Behavior.

As is evidenced by Table VII, there is a definite increase in the frequency of behavior problems so that Period III has one-third more than Period I. Closer observation reveals that this increase is weighted, and is particularly significant in connection with the prevalence of pre-delinquent behavior problems. There were three times as many complaints of lying, stealing and sex delinquencies in Period III than in either of the other two periods. Or looking at the total group of pre-delinquent problems, the frequency in Period III is two-and-a-half times as great as in Period I and three times as great as in Period II. It would seem, therefore, that this type of complaint is more frequent in the school-age child than in the pre-school-age child.

Table VII indicates also a decrease in temper tantrums. This may be suggestive of the fact that older children do not use this method of getting attention or getting their own way as much as does the younger child. Concerning temper tantrums, Harold H. Anderson wrote:

> A temper tantrum is logical and learned behavior. It is the expected outcome of the responding process between a particular child and a particular environment. When environmental demands become too great or too oppressive, or when the child fails to find an opportunity for spontaneity in meeting environmental demands, his behavior may seem to others to become

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bizarre or irrational.[8]

TABLE VII

BEHAVIOR PROBLEMS

Problem	Period I	Period II	Period III
Predelinquent behavior	9	8	26
Fire setting	--	--	2
Lying	2	2	7
Running away	1	--	--
Sadistic action	2	1	2
Sex difficulties	--	--	3
Slyness and cheating	--	1	1
Stealing	3	3	9
Truancy	1	1	2
Other	23	18	17
Attention-getting behavior	2	3	3
Pugnacity & destructiveness	5	4	6
Temper tantrums	16	11	8
Totals	32	26	43

Problems of Motor Disturbance.

There were few cases of children with motor disturbances as indicated in Table VIII. The figures do not show any significant changes in the three

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periods studied. Each year, a number of children with these problems are referred to Clinic. Contrary to expectations, these children are often apt to be seriously disturbed emotionally and require long, intensive treatment.

TABLE VIII

PROBLEMS OF MOTOR DISTURBANCE

Problem	Period I	Period II	Period III
Tics & twitchings	3	--	11
Stuttering or stammering	9	2	6
Other speech difficulties	9	27	6
Poor motor coordination	--	--	1
Sniffing	--	--	1
Falling & convulsive seizures	4	1	1
Other	--	1	--
Totals	25	31	26

Problems of School Adjustment.

The incidence of school problems is increasing. There were only six of these problems referred in Period I. By Period III, the increase is sixfold. This reflects the change in policy of the Clinic. Whereas in its early years it accepted for treatment children of pre-school age, today the Clinic offers services to the older child as well. These figures show too that the Clinic is being used more and more by parents and teachers in

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connection with the various problems that occur in the school environment.

TABLE IX

PROBLEMS OF SCHOOL ADJUSTMENT

Problem	Period I	Period II	Period III
Problems of placement & poor school achievement	5	10	14
Difficult behavior	1	2	1
Poor group adjustment	-	9	11
Dislike for school	-	3	2
Inattention & poor effort	-	2	10
Totals	6	26	38

Miscellaneous Complaints.

There are always a few problems that do not fall into rigid categories. Obviously, this group is small in number and suggests little change over the three periods. It may be of interest to mention, however, that, of all the complaints with regard to vomiting and stomach upset, only two were associated with feeding problems--one in Period I and one in Period II.

Service Rendered.

To embark upon an analysis of social case work treatment would involve a study in itself. Therefore, the writer has grouped the services rendered to the patients at the Clinic into the following two categories:

TABLE IX

PROBLEMS OF SCHOOL ADJUSTMENT

Problem	Period I	Period II	Period III
Problems of placement & poor school achievement	8	10	14
Difficult behavior	1	2	1
Poor group adjustment	-	9	11
Dislike for school	-	3	2
Inattention & poor effort	-	2	10
Totals	8	26	38

TABLE X

MISCELLANEOUS PROBLEMS

Problem	Period I	Period II	Period III
Psychosomatic problems:			
Vomiting & stomach upsets	4	4	5
Abdominal pains	-	-	1
Requests for advice	-	2	1
Psychometric test pending adoption	-	5	2
Diagnosis	-	-	1
Others	-	-	3
Totals	4	11	13

TABLE XI

TYPE OF SERVICE RENDERED TO PATIENTS

Type of Service	Period I	Period II	Period III
Complete service	54	83	77
Partial service	46	17	23
Totals	100	100	100

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Type of Service	Period I	Period II	Period III
Complete service	54	83	77
Partial service	46	17	23
Totals	100	100	100

1. Complete Service -- to include investigation by the psychologist, the psychiatrist, and the social worker, followed by the therapy or advice indicated.

2. Partial Service -- investigation by any of the Clinic staff which falls short of complete service.

This division of service does not take into account the intensity of treatment nor the length of treatment. A partial-service case may call for intensive psychiatric treatment. Nonetheless, it falls within this category precisely because it does not call for the combined efforts of the full Clinic team.

Table XI shows that a greater number of patients received complete service in Periods II and III than in Period I. This may be partially accounted for by the fact that in the early years of the Clinic the bulk of the patients were referred by agencies and very often without adequate preparation of the parents with regard to the work of the Clinic. In many instances, referrals were made on the basis of a need seen by the social worker rather than by the parent. This would naturally make for a lesser degree of cooperation on the part of parents. In more recent years, it has been the policy of the Clinic to encourage parents whenever possible to make the initial contact themselves, even when referral is being made by an agency, thus giving the parent a participating and active role from the start.

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CHAPTER V

THE FAMILY BACKGROUNDS OF THE CLINIC PATIENTS

Mention was made previously of the role that environmental factors play in the growth of the child. Of considerable importance and significance in child guidance work is the patient's family background and history. What are his parents like? Are they native or foreign-born individuals whose viewpoints about raising children differ from those of native born? How well educated are these parents? In other words, do the Clinic patients come from a poor social and economic environment, or are their problems common to all walks of society? These and many similar questions must be raised in order to discover what the social factors in the backgrounds of the patients are and then to see what changes, if any, are discernable over the course of years studied.

Type of Home.

The type of home was classified as normal, broken, compound, and other, according to the following interpretations:

Normal: a home wherein both parents were living.

Broken: a home in which parents are either separated or divorced.

Compound: a home with one or both natural parents in addition to other relatives.

Other: homes that do not fall into these categories, such as foster homes, adoptive homes, etc.

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Table XII indicates that in all three periods the majority of clinic patients came from normal homes. There was a slight increase in Period III of children coming from broken and compound homes. This may be due, in part, to the war, particularly in those cases where mothers whose husbands were called to military service found it financially expedient to live with relatives. This is purely speculative, since the reasons why the families lived with relatives were not studied.

TABLE XII

MARITAL STATUS OF THE PARENTS OF PATIENTS

Marital Status	Total	Period I	Period II	Period III
Normal family	210	74	72	64
Broken home	19	5	5	9
Compound home	42	14	12	16
Other	24	6	8	10
Unknown	5	1	3	1
Totals	300	100	100	100

Nativity of Parents.

There was a greater number of native born parents in Period III than in either of the other two periods. In Period I only twenty-nine per cent of the parents fell into this category, whereas in Period III sixty-three per cent did -- an increase of thirty-four per cent in the number of native born parents. The number of parents who were both foreign born is

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in inverse proportion -- forty per cent in Period I as compared with six per cent in Period III, a decrease of thirty-four per cent.

TABLE XIII

NATIVITY OF THE PARENTS OF PATIENTS

Nativity	Total	Period I	Period II	Period III
Both parents native-born	146	29	54	63
One parent native-born	60	17	23	20
Both parents foreign-born	64	40	18	6
Unknown	30	14	5	11
Totals	300	100	100	100

Education of Parents.

It may be assumed that the formal education of the parents plays some role in their handling of their children, however unmeasurable that role may be. The extent formal education of the parents of the patients studied is tabulated on Table XIII according to the following categories:

1. Little or no education -- parents who have had less than eighth grade schooling.
2. Grammar school -- parents who have completed the eighth or ninth grades of school.
3. High school -- parents who have had at least two years or more of high school training.
4. Business or professional training -- parents who have studied

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Both parents native-born	146	29	54	63
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Unknown	50	14	5	11
Totals	300	100	100	100

Education of Parents.

It may be assumed that the formal education of the parents plays some role in their handling of their children, however unmeasurable that role may be. The extent formal education of the parents of the patients studied is tabulated on Table XIII according to the following categories:

1. Little or no education -- parents who have had less than eighth grade schooling.
2. Grammar school -- parents who have completed the eighth or ninth grades of school.
3. High school -- parents who have had at least two years or more of high school training.
4. Business or professional training -- parents who have studied

either business or a profession, such as nursing, in other than a college setting.

5. College -- parents who have had two years or more of college training.

TABLE XIV

THE EXTENT OF THE FORMAL EDUCATION OF THE PARENTS

Amount of Schooling	Period I		Period II		Period III		Total
	Mo.	Fa.	Mo.	Fa.	Mo.	Fa.	
Little or no schooling	17	16	13	13	5	9	73
Grammar school	17	12	17	13	12	16	87
High school	8	2	35	28	43	18	134
Business or professional school	1	--	9	4	11	4	29
College	--	2	10	17	12	28	69
Other	2	3	2	2	--	2	11
Unknown	55	65	14	23	17	23	197
Totals	100	100	100	100	100	100	600

To draw specific conclusions about the education of the parents would not be fair, in view of the very high percentage of unknowns in Period I. But there are some obvious observations that can be made fairly. Despite the high number of unknowns in Period I, there were more parents who had little or no education in this period than in either of the other two periods. Also, in comparing Period II with Period III, the number of

either business or a profession, such as nursing, in other than a college setting.

3. College -- parents who have had two years or more of college training.

TABLE XIV

THE EXTENT OF THE FORMAL EDUCATION OF THE PARENTS

Amount of Schooling	Period I		Period II		Period III		Total
	Mo.	Fa.	Mo.	Fa.	Mo.	Fa.	
Little or no schooling	17	18	13	13	8	9	78
Grammar school	17	12	17	13	12	16	87
High school	8	2	36	28	43	18	134
Business or professional school	1	--	9	4	11	4	29
College	--	2	10	17	12	28	69
Other	2	3	2	2	--	2	11
Unknown	55	65	14	23	17	23	197
Totals	100	100	100	100	100	100	600

To draw specific conclusions about the education of the parents would not be fair, in view of the very high percentage of unknowns in Period I. But there are some obvious observations that can be made fairly. Despite the high number of unknowns in Period I, there were more parents who had little or no education in this period than in either of the other two periods. Also, in comparing Period II with Period III, the number of

mothers who had some high school training is greater in Period III. But fathers who attended high school dropped from twenty-eight in Period II to eighteen in Period III. At the same time, the number of fathers with college training increased by eleven in Period III. The totals show that the number of parents who had high school training was about the same for Periods II and III, but the total number of parents with college training increased from twenty-seven in Period II to forty in Period III. It is of significance to mention, too, that the number of parents with college education in Period I was negligible.

Physical Health of Parents.

The physical and mental health of the parents certainly plays a part in their attitudes towards their children. A physically or mentally unwell person is not as apt to be understanding and patient with others, even with the members of his own family. Because of the large number of unknowns regarding the physical health of the parents, it would not be valid to draw conclusions from the figures on Table XV. Of those figures available for comparison, however, one can make the general assumption that at least half or more of the parents of the clinic patients enjoyed normal physical well being, and that this factor, therefore, did not play too significant a part in the problems of the children.

Mental and Emotional Health of the Parents.

That the mental and emotional health of the parents conditions the development of the child is undeniable. In tabulating this information it is not the writer's aim to determine the extent of this influence, but rather to obtain a general picture of the emotional and mental status of the

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TABLE XV

PHYSICAL HEALTH OF THE PARENTS OF PATIENTS

State of Physical Health	Period I		Period II		Period III		Total
	Mo.	Fa.	Mo.	Fa.	Mo.	Fa.	
Normal well-being	57	57	63	63	55	54	349
Chronic illnesses or complaints	30	16	16	13	18	13	106
Unknown	13	27	21	24	27	33	145
Totals	100	100	100	100	100	100	600

TABLE XVI

MENTAL HEALTH OF PARENTS OF PATIENTS

State of Mental Health	Period I		Period II		Period III		Total
	Mo.	Fa.	Mo.	Fa.	Mo.	Fa.	
Mental health normal	33	34	44	49	31	48	239
Emotional instability	2	2	8	4	5	4	25
History of diagnosed mental illness	6	1	3	2	12	3	27
Alcoholism and irresponsibility	--	11	1	5	1	9	27
Immorality and other vices	5	2	3	3	2	1	16
Irritability and nervousness	17	8	17	11	20	8	81
Other symptoms	5	4	1	--	1	--	11
Unknown	32	38	23	26	28	27	174
Totals	100	100	100	100	100	100	600

TABLE XV

PHYSICAL HEALTH OF THE PARENTS OF PATIENTS

State of Physical Health	Period I		Period II		Period III		Total
	No.	Pa.	No.	Pa.	No.	Pa.	
Normal well-being	57	57	63	63	56	54	343
Chronic illnesses or complaints	30	18	16	13	18	18	106
Unknown	13	25	21	24	27	28	148
Totals	100	100	100	100	100	100	600

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State of Mental Health	Period I		Period II		Period III		Total
	No.	Pa.	No.	Pa.	No.	Pa.	
Mental health normal	38	36	44	49	31	48	239
Emotional instability	2	2	8	4	5	4	25
History of diagnosed mental illness	6	1	3	2	12	3	27
Alcoholism and irresponsibility	--	11	1	6	1	9	27
Immorality and other vices	6	2	3	3	2	1	16
Irritability and nervousness	17	8	17	11	20	8	81
Other symptoms	6	4	1	--	1	--	11
Unknown	32	32	23	26	28	27	174
Totals	100	100	100	100	100	100	600

parents of the clinic patients. Because subjective factors are bound to enter into this type of classification and because of the large number of parents on whom data are not given in the records, any conclusions drawn from Table XVI would not be valid. Suffice it, therefore, to mention that there seems to be a greater number of parents in Period III who declared the existence of mental illness. Inasmuch as there has been a tendency to stigmatize mental illness, it may be possible that these figures do not indicate a true picture. Another factor seems to stand out and that is that in all three periods there was a greater number of mothers than fathers who considered themselves nervous.

Table XVII indicates the prevalence of any history of mental or emotional difficulties in the relatives of the patients -- both maternal and paternal relatives. Although it points to the fact that in Period III there appeared to be a decrease in the number of families presenting no outstanding problems, the reader should take into account the fact that there were also a larger number of families in this same period whose backgrounds were not known.

Economic Status of the Families.

It was considered important to study the degree of economic security in the families of the patients, because that is one factor that determines the social status of a family and might well affect a child's adjustment. However, clinic records afforded little factual material on the subject. In many instances the economic conditions of the families were described as marginal or comfortable and the subjectivity of worker's standards was apt to color her estimate of the actual economic status. For this reason, the

parents of the clinic patients. Because subjective factors are bound to enter into this type of classification and because of the large number of parents on whom data are not given in the records, any conclusions drawn from Table XVI would not be valid. Suffice it, therefore, to mention that there seems to be a greater number of parents in Period III who declared the existence of mental illness. Inasmuch as there has been a tendency to stigmatize mental illness, it may be possible that these figures do not indicate a true picture. Another factor seems to stand out and that is that in all three periods there was a greater number of mothers than fathers who considered themselves nervous.

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TABLE XVII

OUTSTANDING FACTORS IN RELATIVES,
MATERNAL AND PATERNAL

Problem	Period I	Period II	Period III	Total
No outstanding problems	47	49	38	134
History of illness or insanity	9	6	8	23
Mental retardation	2	3	8	13
History of alcoholism	9	3	1	13
History of convulsions	9	1	1	11
Unknown	24	37	42	103
Other	--	1	2	3
Totals	100	100	100	300

cases were divided into the following two groups: children who came from dependent families and children who came from independent families.

On the whole, the majority of the clinic patients came from families that were economically independent. The greatest number of dependent families occurred in Period II. This is to be expected since Period II represents the era of economic depression. In the economically dependent families, the breadwinners were almost unanimously the fathers, in keeping with the prevailing culture pattern in which fathers are the main support of the family.

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Totals	100	100	100	300

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TABLE XVIII

ECONOMIC STATUS OF THE FAMILIES

Economic Status	Period I	Period II	Period III
Dependent	7	17	8
Independent	90	79	92
a.Father working	86	75	88
b.Mother working	4	3	1
c.Both working	--	1	3
Unknown	3	4	--
Totals	100	100	100

Occupation of the Breadwinner.

Table XIX shows the various occupations of the breadwinners. There was a considerably greater number of professional parents in Period III than in the other two periods. This is in keeping with the greater number of parents who were graduated from college in this particular period. There was no great change in the percentage of parents that fell into the laboring class. One reason for this may be due to the fact that many fathers during the war entered war industries in order to avoid military service. Of those fathers in the service, two were definitely known to have been lawyers and would under ordinary circumstances fall into the professional group. The number of fathers engaged in trades dropped in Periods II and III, but at the same time there was a sizeable rise in the number of fathers

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engaged in business in these two periods and a slight increase in the number of fathers engaged in white collar work.

TABLE XIX

OCCUPATIONS OF THE BREADWINNER

Occupation	Period I	Period II	Period III
Businessmen	9	19	17
Retired individual	3	2	1
Laborers & domestic workers	34	26	30
Professional men	1	9	12
Tradesmen	31	8	8
Servicemen	--	--	8
White collar workers	12	15	16
Unknown	3	4	--
Totals	93	83	92

Contacts with Other Social Agencies.

Further light is thrown on the economic and social status of the families by the data on the number of families dealt with by various other social agencies. This data should not be translated too literally, but may be indicative of a general picture regarding the needs of the families for outside help.

Table XX shows that there were more agency contacts in Period I than in either of the other two periods, with a steadily decreasing number

Occupation	Period I	Period II	Period III
Businessmen	3	19	17
Retired individual	3	2	1
Laborers & domestic workers	34	28	30
Professional men	1	9	12
Tradesmen	31	8	8
Servicemen	--	--	8
White collar workers	12	18	16
Unknown	9	4	--
Totals	93	88	92

of contacts through the years. The greatest number of contacts with public welfare agencies occurred in Period II during the time of economic depression. With regard to frequency of agency contacts, Table XXI shows that there were fifty-eight families in Period III that had had no previous agency contact as compared to twenty in Period I and forty-three in Period II. Also, there were more families in Period I that had had three or more agency contacts than in either of the other two periods.

TABLE XX

AGENCIES TO WHOM FAMILIES WERE KNOWN

Agency	Period I	Period II	Period III
Child placing agencies	38	21	11
Family agencies	43	29	23
Health agencies	100	41	12
Hospitals	84	25	32
Public welfare agencies	22	43	21
Other	75	36	33
Totals	362	195	132

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AGENCIES TO WHOM FAMILIES WERE KNOWN

Agency	Period I	Period II	Period III
Child placing agencies	38	21	11
Family agencies	45	29	23
Health agencies	100	41	12
Hospitals	84	25	32
Public welfare agencies	22	43	21
Other	73	36	33
Totals	362	195	132

TABLE XXI

FREQUENCY OF AGENCY CONTACT

Number of Agency Contacts	Period I	Period II	Period III
No contact	20	43	58
1 - 2	29	27	23
3 - 4	16	13	8
5 - 6	13	6	3
7 - 8	10	3	1
9 - 10	4	1	3
11 - 12	3	3	1
13 - 14	4	1	1
15 - 16	--	--	2
17 - 18	1	--	--
Unknown	--	3	--
Totals	100	100	100

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Number of Agency Contacts	Period I	Period II	Period III
No contact	20	43	58
1 - 2	28	27	23
3 - 4	18	13	8
5 - 6	13	6	3
7 - 8	10	3	1
9 - 10	4	1	3
11 - 12	3	3	1
13 - 14	4	1	1
15 - 16	--	--	2
17 - 18	1	--	--
Unknown	--	3	--
Totals	100	100	100

CHAPTER VI

SUMMARY AND CONCLUSIONS

The Habit Clinic for Child Guidance, Inc., has been in existence for almost twenty-five years, and this study on intake reveals that certain definite changes have taken place during this period.

The Clinic serves a greater geographic radius today than ever before with patients coming from distances as great as fifty miles. About fifty per cent of the patients today are referred directly by their parents, as compared to only four per cent in the early years of the Clinic's existence. At the same time, the number of referrals by agencies has dropped from ninety per cent in the beginning years to thirty-five per cent in present years. Yet, the number of agencies represented now is decidedly larger. It would, therefore, seem that the popularity of the Clinic has consistently been on the increase, with more and more parents recognizing and availing themselves of the services offered.

In all three periods the number of boys was greater than the number of girls and statistics point towards an ever-increasing number of boys over girls, with seventy-two boys and only twenty-eight girls in Period III. The reason for this is not wholly explicable, as census figures for the City of Boston point to a more even distribution of boys and girls under the age of fourteen among the general population.

There is a change too in the religious distribution of the applicants, from a predominance of Catholics in Period I (forty-five per cent) to

CHAPTER VI

SUMMARY AND CONCLUSIONS

a more even distribution of Catholics, Jews and Protestants in Period III, with the number of Jewish patients taking the lead (thirty-two per cent), followed by Protestants (twenty-eight per cent) and Catholics (twenty-one per cent).

Certainly, the Clinic's change of policy to serve children up to twelve years of age is in keeping with the needs of the community, since statistics show a much larger percentage of children in the age group between six and twelve than in the pre-school age level. In Period III alone, sixty-six per cent, or two-thirds, of the applicants fall into this older group.

There is a decided decrease of problems of habit formation in recent years. It would therefore seem that both parents and agencies have learned to distinguish between the more simple and the more complex type of problem, handling the simpler ones themselves. Problems of personality formation have not changed very much, but there appears to be an increase in problems of pre-delinquent behavior and school problems. This may be accounted for by the increase in the number of older children coming to Clinic now. Furthermore, the increase in the number of school problems may also reflect a greater recognition by the schools and by the parents that problems relating to school may be significant of deeper emotional and psychological maladjustment.

A greater number of patients nowadays receives complete service. It may be that parents now feel they are getting more from the Clinic than did parents in the early years of the Clinic's existence, when child guidance work was still in the experimental stages. But the writer feels, too, that parents today are better prepared and better oriented to the Clinic's

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function than they were previously.

Most of the Clinic patients come from families in which both natural parents are living and a very small percentage of them come from homes where the parents are divorced or separated. Sixty-three per cent of the parents in Period III were both native born, as compared with twenty-nine per cent in Period I. It may safely be assumed that chances for cultural conflict in Period III, therefore, would be less than in Period I.

One would expect that a higher percentage of parents received some sort of formal education in Period III, in view of the greater number of native-born parents in this period. This, apparently, is the case. Thirty-one-and-a-half per cent of the parents in Period II and thirty-and-a-half per cent in Period III have had at least two or more years of high school training, as compared with only five per cent in Period I. Too, there is a steady increase in the number of parents who have had some college education, with Period III taking the lead with twenty per cent, followed by Period II with thirteen-and-a-half per cent and Period I with only one per cent.

The majority of the parents enjoyed normal physical and mental health, a fact that would lead one to assume that the problems of the patients probably lie in the area of parent-child relationship rather than stem from physical and mental difficulties of the parents. Of course, it would not be too valid to draw any definite conclusions about the mental health of the parents because of the large number of parents whose situation is not recorded in the case material. Of the data recorded, however, the existence of mental illness or mental deficiency in the families of the patients is very small.

Most of the families of the patients were economically independent;

less than ten per cent each in Periods I and III were dependent. In Period II, however, the dependency rate was higher, amounting to seventeen per cent; but this is explained by the fact that Period II happens to represent a period of economic depression. In the great majority of the families, the fathers were the breadwinners, indicating that the problems of the patients need not necessarily have arisen because of the child's physical separation from the mother.

In all three periods, about one-third of the fathers were engaged in unskilled or menial labor. But there is a noticeable shift in the other types of occupation in the three periods, with Period III taking the lead in having twelve fathers engaged in professional work as compared to nine in Period II and only one in Period I. The number of fathers engaged in white collar jobs or in business is also greater in Periods II and III, so that it may be generally said that in recent years fathers are engaged in either professional or white collar jobs.

More patients today come from families who have had no previous contact with other agencies. Whereas in Period I this group of parents amounted to only twenty per cent, in Period II it increased to forty per cent and in Period III to fifty-eight per cent. Also, there were more families known to three or more agencies in Period I than in either of the other subsequent periods. There were fifty-one known to three or more agencies in Period I as compared to twenty-seven in Period II and nineteen in Period III. Of those families known to just one or two agencies, the agencies concerned in the majority of the cases were either health agencies or hospitals.

In conclusion, this study reveals considerable growth and progress made by the Habit Clinic for Child Guidance, Inc., in the last twenty-five

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In conclusion, this study reveals considerable growth and progress made by the Habit Clinic for Child Guidance, Inc., in the last twenty-five

years. It serves today a much larger geographic area than ever before and there is a trend towards a more even distribution of the three dominant religious groups of Catholics, Protestants and Jews than there was previously. Certainly, the increase in the number of applicants over the pre-school age level shows flexibility in the Clinic's policy to change its function to meet the needs of the community. With this age-group increase, one notes too a change in the types of problems referred. Problems of habit formation have decreased, whereas problems of pre-delinquent behavior as well as problems pertaining to school have increased. These types of problems are often more complicated and call for more intensive treatment. Too, the fact that a greater number of parents are now better educated, the fact that the jobs they are engaged in are commensurate with the degree of formal education they have had, and the fact that more patients nowadays come from families who have had no previous contact with other social agencies would lead one to conclude that on the whole the majority of clinic patients today come from families of a higher social and economic stratum than did those previously. It has been determined, too, that there are more patients today receiving complete treatment than there were in the earlier years of the clinic's existence. Whether this is directly due to the fact that parents today are better educated or to the fact the type of treatment has changed, in keeping with the whole growth of child guidance work and its associated fields, has not been determined. But, generally speaking, these aggregate findings seem to point to the need for the continuance of this work, the need for the extension of the staff and the need for greater facilities to meet the present pressures.

Approved,

Richard K. Conant

Dean

Approved,

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APPENDIX

APPENDIX

TABLE XXII

AGENCY REFERRALS

Source	Period I	Period II	Period III	Total
Agencies	66	26	14	106
Am. League Against Epilepsy	--	--	1	1
American Red Cross	--	1	--	1
Baby Hygiene Clinics	31	--	--	31
Catholic Charitable Bureau	--	--	1	1
Children's Aid	--	3	--	3
Children's Friend	--	--	1	1
Church Home Society	--	2	1	3
Community Health Ass'n	8	13	--	21
District Nursing Ass'n	11	--	1	12
Division of Mental Hygiene	1	--	--	1
Ellis Memorial Agency	1	--	--	1
Family Welfare Society	--	4	3	7
Haverhill Children's Aid	--	1	--	1
Jewish Family Welfare	1	--	--	1
Morgan Memorial Nursery	1	--	--	1
Neighborhood Kitchen	2	--	--	2
N.E. Home for Little Wanderers	--	--	1	1
Newton Family Society	--	2	4	6
Ruggles St. Nursery School	10	--	1	11
Settlement Houses	19	4	1	24
Hale House	--	--	1	1
Robert Gould Shaw House	--	1	--	1
Roxbury Neighborhood House	3	--	--	3
South Bay Union	16	1	--	17
South Boston Neighborhood House	--	2	--	2
Hospitals	5	12	20	37
Boston City Hospital	1	7	3	11
Children's Hospital	1	3	15	19
Others	3	2	2	7
Totals	90	42	35	167

TABLE XXIV

AGENCY REFERRALS

Source	Period I	Period II	Period III	Total
Agencies	68	26	14	108
Am. League Against Epilepsy	--	--	1	1
American Red Cross	--	1	--	1
Baby Hygiene Clinics	31	--	--	31
Catholic Charitable Bureau	--	--	1	1
Children's Aid	--	3	--	3
Children's Friend	--	--	1	1
Church Home Society	--	2	1	3
Community Health Ass'n	8	13	--	21
District Nursing Ass'n	11	--	1	12
Division of Mental Hygiene	1	--	--	1
Ellis Memorial Agency	1	--	--	1
Family Welfare Society	--	4	3	7
Havenhill Children's Aid	--	1	--	1
Jewish Family Welfare	1	--	--	1
Morgan Memorial Nursery	1	--	--	1
Neighborhood Kitchen	2	--	--	2
N.E. Home for Little Wanderers	--	--	1	1
Newton Family Society	--	2	4	6
Nuggles St. Nursery School	10	--	1	11
Settlement Houses	19	4	1	24
Hale Houses	--	--	1	1
Robert Gould Shaw House	--	1	--	1
Roxbury Neighborhood House	3	--	--	3
South Bay Union	16	1	--	17
South Boston Neighborhood Houses	--	2	--	2
Hospitals	6	12	20	37
Boston City Hospital	1	7	3	11
Children's Hospital	1	3	15	19
Others	3	2	2	7
Totals	90	42	56	187

TABLE XXIII

REFERRAL OF PARENTS

Person Referring	Period I	Period II	Period III	Total
Mother	4	36	25	65
Father	--	3	2	5
Mother at suggestion of:				
Physician	--	4	2	6
Tutor	--	1	--	1
School	--	2	8	10
Former client	--	1	--	1
Nurse	--	2	5	7
Friend	--	--	3	3
Agency	--	--	3	3
Relative	--	--	1	1
Totals	4	49	49	102

TABLE XLII

REFERRAL OF PARENTS

Person Referring	Period I	Period II	Period III	Total
Mother	4	36	26	66
Father	--	3	2	5
Mother at suggestion of:				
Physician	--	4	2	6
Tutor	--	1	--	1
School	--	2	8	10
Former client	--	1	--	1
Nurse	--	2	5	7
Friend	--	--	3	3
Agency	--	--	3	3
Relative	--	--	1	1
Totals	4	49	49	102

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